SECTION 11

Other services

Dialysis
Hospice
Clinical laboratory

Chart 11-1. Number of dialysis facilities is growing and share of for-profit and freestanding dialysis providers is increasing

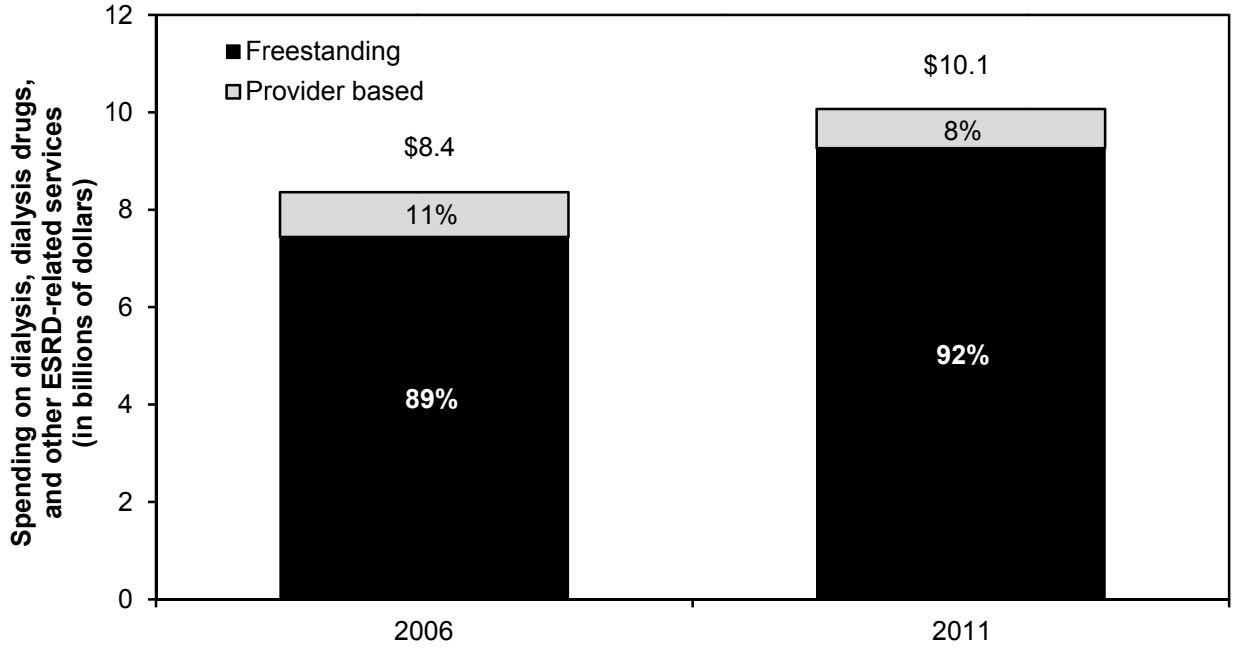
	2012	Average annual percent change 2007–2012	Average annual percent change 2011–2012
Total number of:			
Dialysis facilities	5,811	3%	2%
Hemodialysis stations	103,092	4	3
Mean number of hemodialysis stations per facility	18	0.4	0.3
	Percent of total		
Hospital based	9%	–4	–9
Freestanding	91	4	4
Urban	79	4	3
Rural, micropolitan	13	2	1
Rural, adjacent to urban	5	3	2
Rural, not adjacent to urban	3	3	2
Frontier	1	–1	0
For profit	85	5	4
Nonprofit	15	–2	–7

Note: Nonprofit includes facilities designated as either nonprofit or government. Average annual percent change based on comparing 2007, 2011, and 2012 end-of-year files.

Source: Compiled by MedPAC from the 2007, 2011, and 2012 CMS Dialysis Compare end-of-year files.

- Between 2007 and 2012, the number of freestanding and for-profit facilities increased, while hospital-based and nonprofit facilities decreased. Freestanding facilities increased from 88 percent to 91 percent of all facilities, and for-profit facilities increased from 81 percent to 85 percent of all facilities.
- Between 2007 and 2012, the proportion of facilities located in rural areas has remained relatively constant.
- Since 2007, the number of facilities has increased 3 percent per year. The average size of a facility has remained relatively constant, averaging about 18 dialysis treatment stations per facility.

Chart 11-2. Medicare spending for outpatient dialysis services furnished by freestanding and hospital-based dialysis facilities, 2006 and 2011



Note: ESRD (end-stage renal disease).

Source: Compiled by MedPAC from the 2006 and 2011 institutional outpatient files from CMS.

- In 2011, total spending for dialysis, dialysis drugs, and ESRD-related clinical laboratory tests was $10.1 billion. For most facilities, 2011 is the first year that Medicare paid them using a modernized prospective payment that includes in the payment bundle certain dialysis drugs and ESRD-related clinical laboratory tests for which facilities and clinical laboratories previously received separate payments.

- Between 2006 and 2011, total ESRD expenditures increased by about 4 percent per year. Excluding items and services (such as clinical laboratory services) that Medicare paid other providers (not dialysis facilities) to furnish before 2011, we estimate that annual growth in spending was roughly 3 percent per year.

- Freestanding dialysis facilities treat most dialysis beneficiaries and accounted for 89 percent of expenditures in 2006 and 92 percent of expenditures in 2011.

Chart 11-3. The ESRD population is growing, and most ESRD patients undergo dialysis

	2000		2006		2010	
	Patients (thousands)	Percent	Patients (thousands)	Percent	Patients (thousands)	Percent
Total	393.0	100%	508.9	100%	594.4	100%
Dialysis	284.2	72	357.4	70	415.0	70
In-center hemodialysis	255.5	65	327.7	64	378.5	64
Home hemodialysis*	2.2	1	2.6	1	5.5	1
Peritoneal dialysis*	25.3	6	26.2	5	29.8	5
Unknown	1.1	0.3	1.0	0.2	1.3	0.2
Functioning graft and kidney transplants	108.8	28	151.5	30	179.4	30

Note: ESRD (end-stage renal disease). Totals may not equal sum of components due to rounding. Data include both Medicare and non-Medicare patients.
* Home dialysis methods.

Source: Compiled by MedPAC from the United States Renal Data System.

- Persons with ESRD require either dialysis or a kidney transplant to maintain life. The total number of ESRD patients increased by 4 percent annually between 2000 and 2010.
- In hemodialysis, a patient's blood flows through a machine with a special filter that removes wastes and extra fluids. In peritoneal dialysis, the patient's blood is cleaned by using the lining of his or her abdomen as a filter. Peritoneal dialysis is the most common form of home dialysis.
- Most ESRD patients undergo hemodialysis administered in a dialysis facility three times a week. Between 2000 and 2010, the total number of in-center hemodialysis patients increased by 4 percent annually while the number of peritoneal dialysis patients increased 2 percent annually. Although only a small proportion of all dialysis patients undergo home hemodialysis, the number of these patients grew 10 percent per year during this time period.
- Functioning graft patients are patients who have had a successful kidney transplant. Patients undergoing kidney transplant may receive either a living kidney or a cadaveric kidney donation. In 2010, about 35 percent of transplanted kidneys were from living donors and the remainder were from cadaver donors.

Chart 11-4. Asian Americans and Hispanics are among the fastest growing segments of the ESRD population

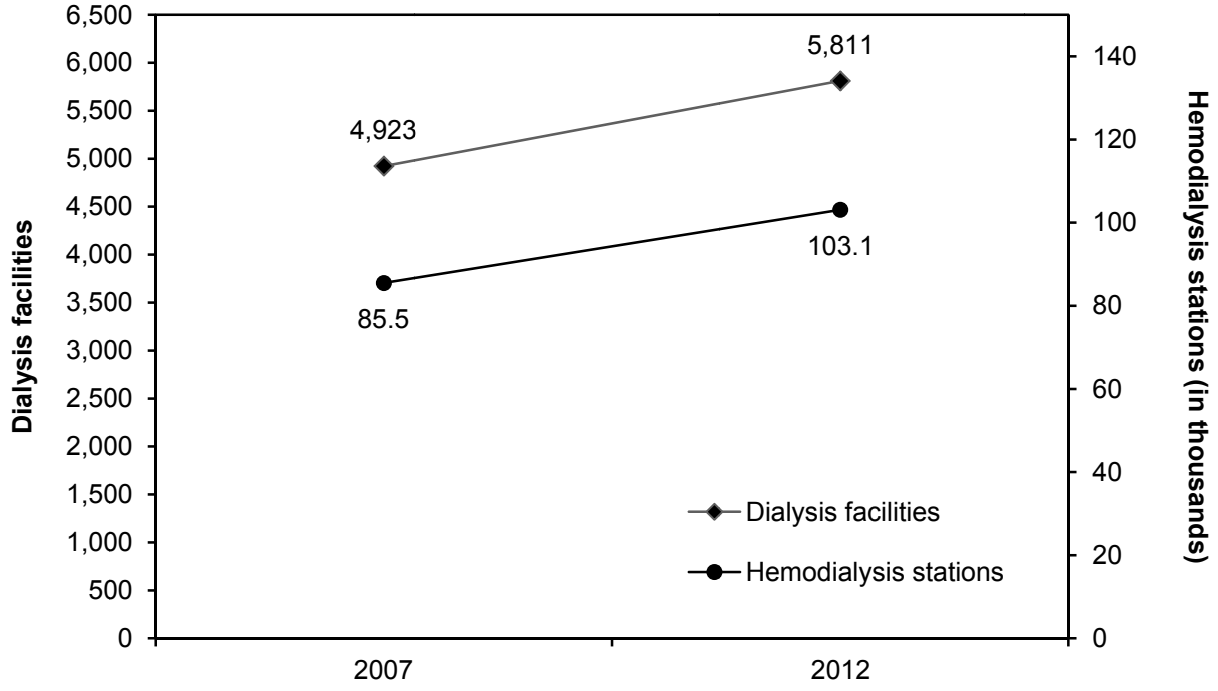
	Percent of total in 2010	Average annual percent change 2005–2010
Total (*n* = 594,374)	100%	4%
Age (years)		
0–19	1	1
20–44	17	1
45–64	45	5
65–79	28	5
80+	9	5
Sex		
Male	57	4
Female	43	4
Race/ethnicity		
White	61	4
African American	32	4
Native American	1	4
Asian American	6	8
Hispanic	16	7
Non-Hispanic	84	4
Underlying cause of ESRD		
Diabetes	38	4
Hypertension	25	4
Glomerulonephritis	15	2
Other causes	23	4

Note: ESRD (end-stage renal disease). Totals may not equal sum of the components due to rounding. ESRD patients include those who undergo maintenance dialysis and those who have a functioning kidney transplant.

Source: Compiled by MedPAC from the United States Renal Data System.

- Among ESRD patients, 37 percent are over age 65. About 61 percent are White.
- Diabetes is the most common cause of renal failure.
- The number of ESRD patients increased by 4 percent annually between 2005 and 2010. Among the fastest growing groups of patients are Asian Americans and Hispanics.

Chart 11-5. Dialysis facilities' capacity increased between 2007 and 2012



Source: Compiled by MedPAC from the Dialysis Compare database from CMS.

- As the number of dialysis patients has grown, dialysis providers have met the demand by opening new facilities. In 2012, an average facility had about 18 hemodialysis stations.
- Between 2007 and 2012, the total number of dialysis facilities grew by about 3 percent annually, and the number of hemodialysis stations grew by 4 percent annually.

Chart 11-6. Characteristics of Medicare fee-for-service dialysis patients, 2011

	Percent of all FFS dialysis patients
Age (years)	
Under 45	12%
45–64	38
65–74	25
75–84	19
85+	7
Sex	
Male	54
Female	46
Race	
White	50
African American	36
All other	14
Residence	
Urban county	81
Rural county, micropolitan	11
Rural county, adjacent to urban	5
Rural county, not adjacent to urban	3
Frontier county	1
Prescription drug coverage status	
Enrolled in Part D plan	72
Coverage through employers that receive RDS	9
Coverage through other creditable sources	8
No creditable coverage	11
LIS	58
Medicare as the secondary payer	9
Dually eligible for Medicaid	47

Note: FFS (fee-for-service). RDS (retiree drug subsidy), LIS (low-income subsidy). Urban counties contain a core area with 50,000 or more population, rural micropolitan counties contain at least one cluster of at least 10,000 and less than 50,000 population, rural counties adjacent to urban areas do not have a city of 10,000 people in the county, and rural counties not adjacent to urban areas do not have a city of 10,000 people. Frontier counties are counties with six or fewer people per square mile. Totals may not sum to 100 percent due to rounding.

Source: MedPAC analysis of dialysis claims files and denominator files from CMS.

- Compared with all Medicare patients, FFS dialysis patients are disproportionately younger and African American.
- In 2011, about 20 percent of FFS dialysis patients resided in a rural county.
- Nearly half of all dialysis patients were dually eligible for Medicare and Medicaid services.
- Medicare was the secondary payer (for Part A and Part B) for 9 percent of FFS dialysis patients who were insured by an employer group health plan at the time they were diagnosed with end-stage renal disease.
- About 90 percent of FFS dialysis patients were enrolled in Part D plans or had other sources of creditable drug coverage.

Chart 11-7. Aggregate margins vary by type of freestanding dialysis facility, 2010

Type of facility	Percentage of Medicare payments going to freestanding facilities	Aggregate margin
All facilities	100%	2.3%
Urban	85	3.4
Rural	15	–3.7
LDOs	69	3.4
Non-LDOs	31	0.1

Note: LDO (large dialysis organization). Margins include payments and costs for composite rate services and injectable drugs.

Source: Compiled by MedPAC from 2010 cost reports and the 2010 institutional outpatient file from CMS.

- For 2010, the aggregate Medicare margin for composite rate services and injectable drugs was 2.3 percent.
- Because 2011 dialysis cost reports are not yet available, we estimate a range for the 2011 Medicare margin of 2 percent to 3 percent. This estimate is based on 2010 cost reports and 2011 Medicare claims data for freestanding dialysis facilities. The lower end of the range reflects a more conservative assumption about the efficiencies anticipated under the modernized payment bundle. We did not stratify the 2011 Medicare margin by type of dialysis facility because 2011 cost report data were not available.
- In 2010 and in earlier years, we see higher margins for facilities affiliated with the two largest dialysis organizations. This finding stems from differences in the composite rate cost per treatment and drug payment per treatment. Compared with their counterparts, the composite rate cost per treatment was lower and the drug payment per treatment was higher for the two largest chains.

Chart 11-8. Medicare hospice use and spending grew substantially from 2000 to 2011

	2000	2010	2011	Change, 2000–2010	Change, 2010–2011
Beneficiaries in hospice (in millions)	0.534	1.159	1.219	8.1%*	5.2%
Medicare payments (in billions)	$2.9	$13.0	$13.8	16.2%*	6.8%
Average length of stay among decedents (in days)	54	86	86	4.8%*	0.0%
Median length of stay among decedents (in days)	17	18	17	+1 day	–1 day

Note: Average length of stay is calculated for decedents who used hospice at the time of death or before death and reflects the total number of days the decedent was enrolled in the Medicare hospice benefit during his/her lifetime. The percent change in the number of hospice users and total spending displayed in the chart may not equal the percent change calculated using the yearly data displayed in the chart due to rounding.
*Average annual percent change.

Source: MedPAC analysis of the denominator file, the Medicare Beneficiary Database, and the 100 percent hospice claims Standard Analytic File from CMS.

- The number of Medicare beneficiaries receiving hospice services more than doubled between 2000 and 2010 and continued to grow in 2011, suggesting that access to hospice care has increased.
- After growing from 54 days in 2000 to 86 days in 2010, average length of stay held steady between 2010 and 2011.
- Total Medicare payments to hospices more than quadrupled from 2000 to 2011 due to increased hospice enrollment and longer lengths of stay.

Chart 11-9. Hospice use increased across beneficiary groups from 2000 to 2011

	Percent of decedents using hospice			Average annual percentage point change	Percentage point change
	2000	2010	2011	2000–2010	2010–2011
All	22.9%	44.0%	45.2%	2.1%	1.2%
FFS beneficiaries	21.5	43.0	44.2	2.2	1.2
MA beneficiaries	30.9	47.8	48.9	1.7	1.1
Dual eligibles	17.5	39.2	40.3	2.2	1.1
Non–dual eligibles	24.5	45.5	46.8	2.1	1.3
Age (years)					
<65	17.0	27.2	27.8	1.0	0.6
65–84	24.7	42.6	43.7	1.8	1.1
85+	21.4	50.4	52.0	2.9	1.6
Race/ethnicity					
White	23.8	45.8	47.0	2.2	1.2
Minority	17.3	33.6	35.1	1.6	1.5
Gender					
Male	22.4	40.4	41.3	1.8	0.9
Female	23.3	47.2	48.6	2.4	1.4
Beneficiary location					
Urban	24.3	45.5	46.6	2.1	1.1
Micropolitan	18.5	39.8	41.4	2.1	1.6
Rural, adjacent to urban	17.6	38.7	40.2	2.1	1.5
Rural, nonadjacent to urban	15.8	34.5	35.9	1.9	1.4
Frontier	13.2	30.1	30.7	1.7	0.6

Note: FFS (fee-for-service), MA (Medicare Advantage). Beneficiary location reflects the beneficiary's county of residence. Urban, micropolitan, and rural designations are based on the urban influence codes. The frontier category is defined as population density equal to or less than six persons per square mile.

Source: MedPAC analysis of data from the denominator file and the Medicare Beneficiary Database from CMS.

- Hospice use grew in all beneficiary groups in 2011, continuing the trend of a growing proportion of beneficiaries using hospice at the end of life.
- Despite this growth, hospice use continued to vary by demographic and beneficiary characteristics. Medicare decedents who were older, White, female, MA enrollees, not dual eligible, or lived in an urban area were more likely to use hospice than their counterparts.

Chart 11-10. Number of Medicare-participating hospices has increased due to growth in for-profit hospices

	2000	2009	2010	2011
All hospices	2,255	3,385	3,498	3,585
For profit	672	1,834	1,954	2,052
Nonprofit	1,323	1,324	1,319	1,308
Government	258	227	225	225
Freestanding	1,069	2,282	2,397	2,485
Hospital based	785	634	612	597
Home health based	379	447	466	480
SNF based	21	22	23	23
Urban	1,424	2,323	2,430	2,534
Rural	788	1,005	1,002	985

Note: The hospice provider counts shown in this chart differ from the counts show in prior years' chart books because this year we used different data sources, which we believe more accurately capture the number and type of hospices serving Medicare beneficiaries. Numbers may not sum to totals because of missing data for a small number of providers.

Source: MedPAC analysis of Medicare cost reports, Provider of Services file, and the Standard Analytic File of hospice claims from CMS.

- There were nearly 3,600 Medicare-participating hospices in 2011. Most of them were for-profit hospices.
- Between 2000 and 2011, the number of Medicare-participating hospices grew by more than 1,300 providers. For-profit hospices accounted almost entirely for that growth.
- Growth in the number of providers has occurred predominantly among freestanding and home-health-based providers. The number of hospital-based providers has declined.
- The number of hospices in rural and urban areas was substantially higher in 2011 than in 2000, although the number of hospices in rural areas declined modestly in the past few years. The share of hospices located in rural areas (28 percent) and urban areas (72 percent) is similar to the share of Medicare beneficiaries residing in these two types of areas.

Chart 11-11. Hospice cases and length of stay, by diagnosis, 2011

	Diagnosis share of total cases	Percent of cases with length of stay greater than 180 days
Cancer (except lung cancer)	20%	9%
Debility, NOS	11	24
Circulatory, except heart failure	10	18
Lung cancer	8	8
Heart failure	7	20
Unspecific symptoms/signs	6	23
Alzheimer's and similar diseases	6	35
Chronic airway obstruction, NOS	6	26
Dementia	5	30
Organic psychoses	4	28
Respiratory disease	3	10
Genitourinary disease	3	5
Nervous system, except Alzheimer's	3	31
Digestive disease	2	7
Other	1	9
All	100	20

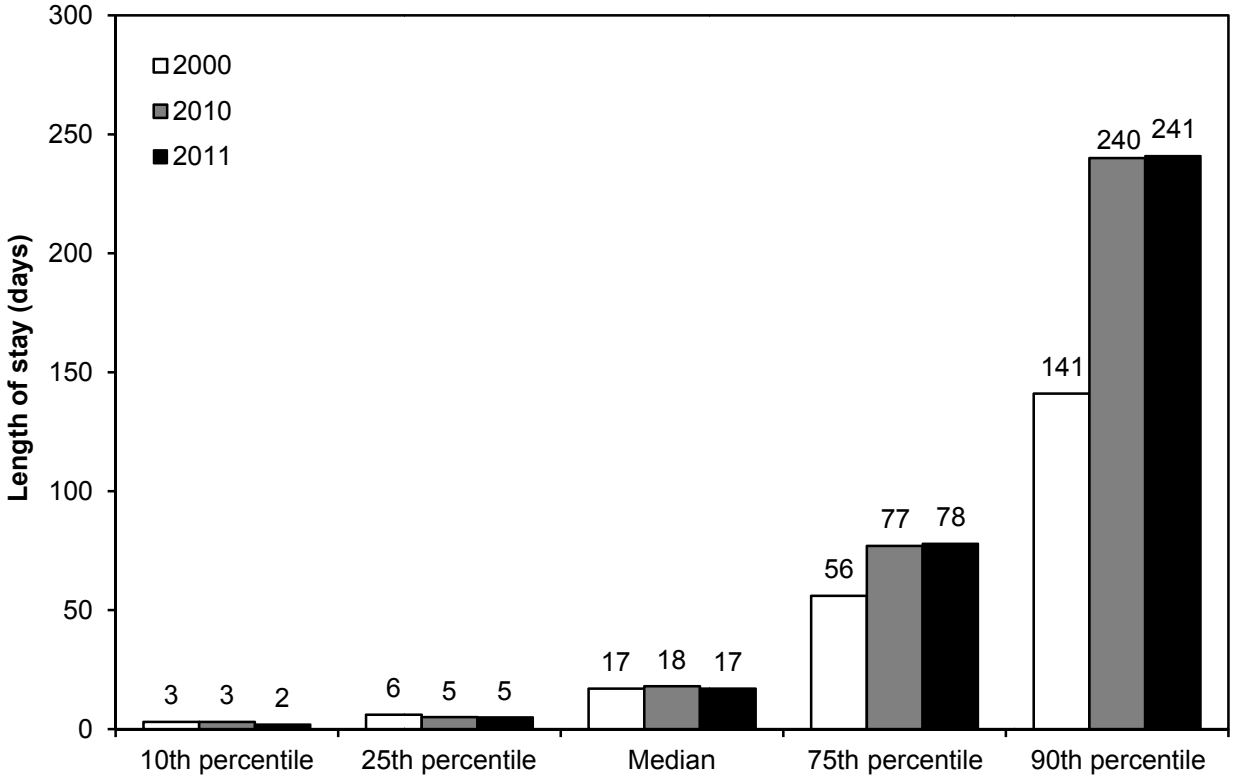
Note: NOS (not otherwise specified). Cases include all patients who received hospice care in 2011, not just decedents. Percent of cases by diagnosis does not sum to 100 due to the exclusion of patients with multiple diagnoses. Share of cases may not sum to figures cited in the text below due to rounding.

Source: MedPAC analysis of 100 percent hospice claims Standard Analytic File from CMS and the Medicare Beneficiary Database.

- In 2011, the most common terminal diagnosis among Medicare hospice patients was cancer, accounting for about 28 percent of cases. The next most common diagnoses were Alzheimer's disease, dementia, organic psychoses, and other neurological conditions (18 percent of cases); debility and unspecific signs and symptoms (17 percent); and heart failure and other circulatory conditions (17 percent of cases).

- Length of stay varies by diagnosis. Nearly one-quarter or more of hospice patients with Alzheimer's disease, dementia, organic psychoses, chronic airway obstruction, debility, and unspecific signs and symptoms had lengths of stay exceeding 180 days. Long hospice stays were least common among beneficiaries with genitourinary disease, digestive disease, and cancer.

Chart 11-12. Growth in length of stay among hospice patients with the longest stays slowed in 2011



Note: Data reflect hospice length of stay for Medicare decedents who used hospice at the time of death or before death. Length of stay reflects the total number of days the decedent was enrolled in the Medicare hospice benefit during his or her lifetime.

Source: MedPAC analysis of the denominator file and the Medicare Beneficiary Database from CMS.

- Since 2000, long hospice stays have grown longer. For example, hospice length of stay among decedents at the 90th percentile was 241 days in 2011 compared with 141 days in 2000, an increase of 100 days. Growth in length of stay at the 90th percentile has been slower in recent years than earlier in the period. The 90th percentile of length of stay increased 1 day between 2010 (240 days) and 2011 (241 days).

- Short stays in hospice have changed little since 2000. The median length of stay in hospice held steady at 17 or 18 days from 2000 to 2011. Hospice length of stay at the 25th percentile has remained at 5 or 6 days since 2000.

Chart 11-13. Hospice length of stay among decedents, by beneficiary and hospice characteristics, 2011

	Average length of stay (in days)	Length of stay percentiles (in days)		
		10th	50th	90th
Beneficiary				
Diagnosis				
Cancer	52	3	17	126
Neurological	137	3	25	423
Heart/circulatory	74	2	11	210
Debility	97	3	23	280
COPD	107	2	20	316
Other	86	2	13	251
Site of service				
Home	88	4	26	231
Nursing facility	111	3	21	332
Assisted living facility	149	5	50	423
Hospice facility or hospital	15	2	4	19
Hospice				
For profit	102	3	21	295
Nonprofit	69	2	14	184
Freestanding	89	2	17	251
Home health based	68	2	15	183
Hospital based	61	2	14	160

Note: COPD (chronic obstructive pulmonary disease). Average length of stay is calculated for Medicare beneficiaries who died in 2010 and used hospice that year and reflects the total number of days the decedent was enrolled in the Medicare hospice benefit during his or her lifetime.

Source: MedPAC analysis of 100 percent hospice claims Standard Analytic File data, Medicare Beneficiary Database, Medicare hospice cost reports, and Provider of Services file data from CMS.

- Hospice average length of stay varies by both beneficiary and provider characteristics. Most of this variation reflects differences in length of stay among patients with the longest stays (e.g., at the 90th percentile). Length of stay varies much less for patients with shorter stays (e.g. at the 10th or 50th percentile).

- Beneficiaries with neurological conditions, COPD, and debility have the longest stays, while beneficiaries with cancer have the shortest stays on average.

- Beneficiaries who receive hospice services in assisted living facilities and nursing facilities have longer stays on average than beneficiaries who receive care at home or in a hospice facility or hospital.

- For-profit and freestanding hospices have longer average lengths of stay than nonprofit and provider-based hospices.

Chart 11-14. More than half of Medicare hospice spending in 2011 was for patients with stays exceeding 180 days

	Medicare hospice spending, 2011 (in billions)
All hospice users in 2011	$13.8
Beneficiaries with LOS > 180 days	7.9
Days 1–180	2.6
Days 181–365	2.5
Days 366+	2.7
Beneficiaries with LOS ≤ 180 days	5.9

Note: LOS (length of stay). LOS reflects the beneficiary's lifetime LOS as of the end of 2011 (or at the time of discharge in 2011 if the beneficiary is not enrolled in hospice at the end of 2011). All spending reflected in the chart occurred only in calendar year 2011. Numbers do not sum to total due to rounding.

Source: MedPAC analysis of 100 percent hospice claims Standard Analytic File data and the common Medicare enrollment file from CMS.

- In 2011, Medicare hospice spending on patients with stays exceeding 180 days was nearly $8 billion, more than half of all Medicare hospice spending that year.
- About $2.7 billion, or nearly 20 percent, of Medicare hospice spending in 2011 was on additional hospice care for patients who had already received at least 1 year of hospice.

Chart 11-15. Hospice aggregate Medicare margins, 2004–2010

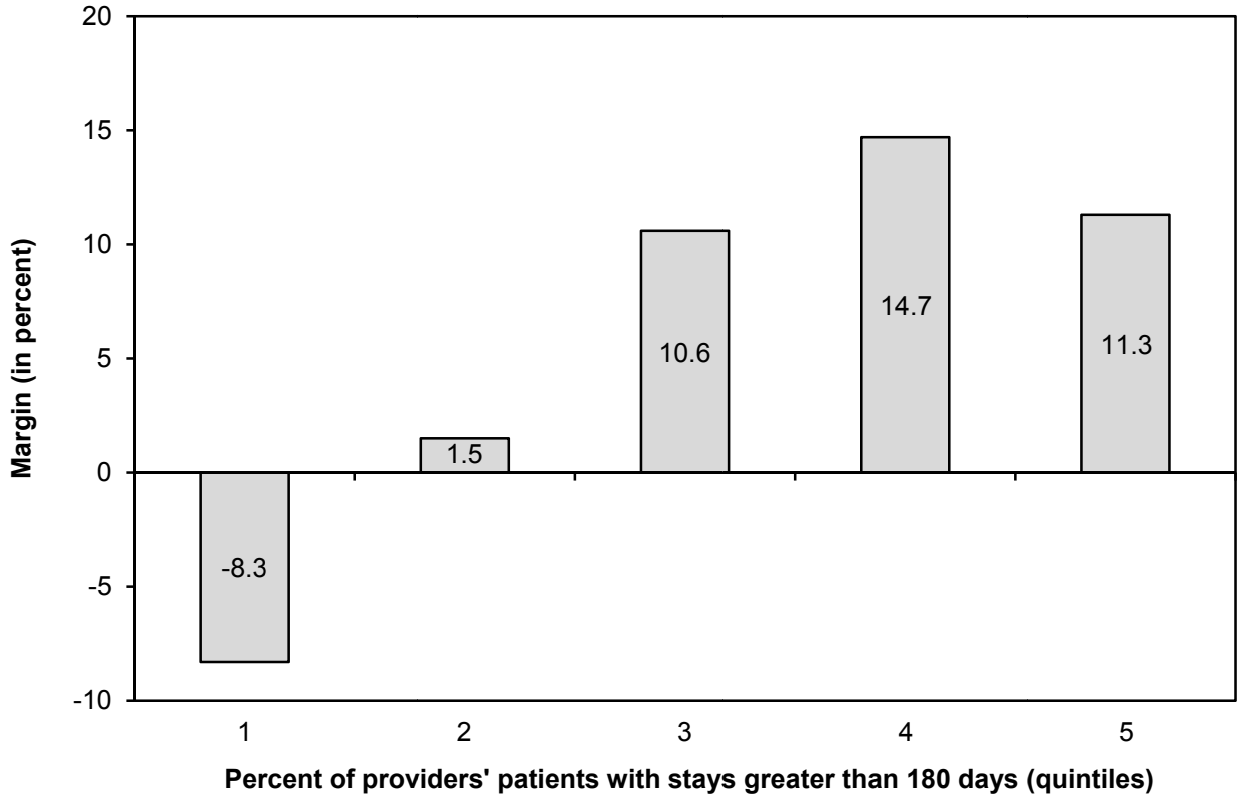
	Percent of hospices (2010)	2004	2007	2008	2009	2010
All	100%	5.0%	5.8%	5.5%	7.4%	7.5%
Freestanding	69	8.3	8.7	8.3	10.2	10.7
Home health based	13	3.1	2.3	3.4	5.9	3.2
Hospital based	17	–11.6	–10.9	–11.3	–12.2	–16.0
For profit	56	11.8	10.4	10.3	11.7	12.4
Nonprofit	38	0.3	1.6	0.7	3.8	3.2
Government	14	N/A	N/A	N/A	N/A	N/A
Urban	71	5.9	6.3	5.9	7.9	7.8
Rural	29	–2.3	1.4	2.1	3.7	5.3
Below cap	89.9	5.6	6.1	5.9	7.9	7.8
Above cap	10.1	–3.4	2.5	1.2	1.4	3.2
Above cap (including cap overpayments)	10.1	18.9	20.5	19.0	18.3	17.3

Note: N/A (not available). Margins for all provider categories exclude overpayments to above-cap hospices, except where specifically indicated. Margins are calculated based on Medicare-allowable, reimbursable costs. Percent of hospices does not sum to 100 by freestanding/provider-based categories because skilled nursing facility–based hospices are not broken out separately. Percent of hospices may not sum to 100 percent for other categories due to rounding.

Source: MedPAC analysis of Medicare hospice cost reports, 100 percent hospice claims Standard Analytic File, and Medicare Provider of Services data from CMS.

- The aggregate Medicare margin was 7.5 percent in 2010, up from 7.4 percent in 2009.
- Margin estimates do not include nonreimbursable costs associated with bereavement services and volunteers (which, if included, would reduce margins by at most 1.4 and 0.3 percentage points, respectively). Margins also do not include the costs and revenues associated with fundraising.
- Freestanding hospices had higher margins than provider-based (home-health- and hospital-based) hospices in part due to differences in their indirect costs. Provider-based hospices' indirect costs are higher than those of freestanding providers and are likely inflated due to the allocation of overhead from the parent provider.
- In 2010, for-profit hospice margins were strongly positive at 12.4 percent. The aggregate margin for nonprofit hospices was 3.2 percent. The subset of nonprofit hospices that were freestanding had a higher margin of 7.6 percent (not shown in chart).
- Hospices that exceeded the cap (Medicare's aggregate average per beneficiary payment limit) had a margin of more than 17 percent before the return of the cap overpayments.

Chart 11-16. Medicare margins are higher among hospices with more long stays, 2010



Note: Margins exclude overpayments to hospices that exceed the cap on the average annual Medicare payment per beneficiary. Margins are calculated based on Medicare-allowable, reimbursable costs.

Source: MedPAC analysis of Medicare hospice cost reports and 100 percent hospice claims Standard Analytic File from CMS.

- Medicare's per diem–based payment system for hospice provides an incentive for longer lengths of stay.
- Hospices with more patients with stays greater than 180 days generally have higher margins. Hospices in the lowest length-of-stay quintile have a margin of –8.3 percent compared with a 14.7 percent margin for hospices in the second highest length-of-stay quintile.
- Margins are somewhat lower in the highest length-of-stay quintile (11.3 percent) compared with the second highest quintile (14.7 percent) because some hospices in the highest quintile exceeded Medicare's aggregate payment cap and were required to repay the overage. Hospices exceeding the cap had a margin of more than 17 percent before the return of overpayments (Chart 11-15).

Chart 11-17. Hospices that exceeded Medicare's annual payment cap, selected years

	2002	2006	2008*	2009*	2010*
Percent of hospices exceeding the cap	2.6%	9.4%	10.2%	12.5%	10.1%
Average payments over the cap per hospice exceeding the cap (in thousands)	$470	$731	$571	$485	$426
Payments over the cap as a percent of overall Medicare hospice spending	0.6%	2.4%	1.7%	1.7%	1.2%

Note: The cap year is defined as the period beginning November 1 and ending October 31 of the following year. These estimates of hospices that exceed the aggregate cap are based on the Commission's analyses. While the estimates are intended to approximate those of the Medicare claims-processing contractors, they are not necessarily identical to the contractors' estimates due to differences in available data and methodology.
*The estimates for 2008, 2009, and 2010 are not entirely comparable to the estimates for 2002 and 2006.

Source: MedPAC analysis of 100 percent hospice claims Standard Analytic File data, Medicare hospice cost reports, Provider of Services file data from CMS, and CMS Providing Data Quickly system. Data on total spending for each fiscal year are from the CMS Office of the Actuary.

- Fewer hospices exceeded Medicare's aggregate average per beneficiary payment limit, or "cap," in 2010 than in 2009. About 10.1 percent of hospices exceeded the cap in 2010, down from 12.5 percent in 2009. This decline may signal the beginning of a reversal to the trend observed over the past decade of an increasing share of hospices exceeding the aggregate cap.
- Medicare payments over the cap represented 1.2 percent of total Medicare hospice spending in 2010.
- On average, above-cap hospices exceeded the cap by about $426,000 per provider in 2010. Since 2006, the amount by which above-cap hospices have exceeded the cap on average has declined each year.

Chart 11-18. Length-of-stay and live discharge rates for above- and below-cap hospices, 2010

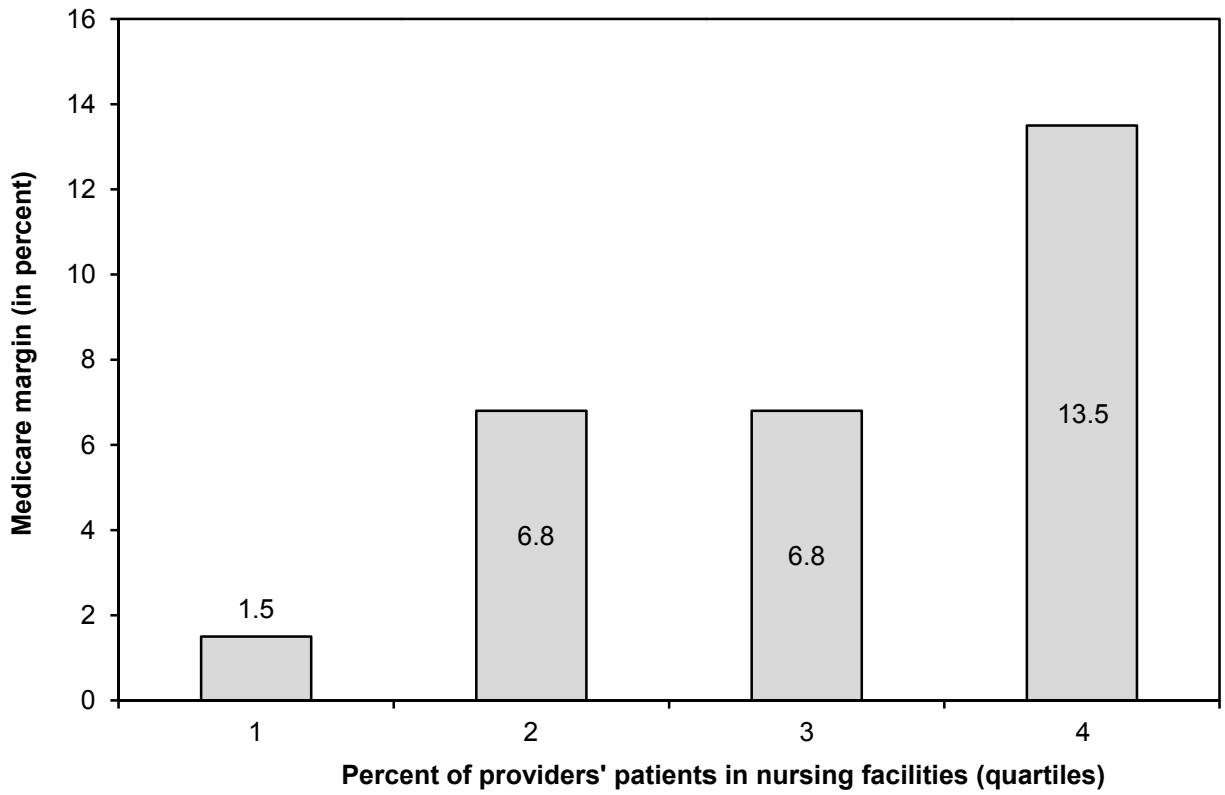
Diagnosis	Percent of hospice users with stays exceeding 180 days		Live discharges as a percent of all discharges	
	Above-cap hospices	Below-cap hospices	Above-cap hospices	Below-cap hospices
All	39%	19%	40%	16%
Cancer	16	9	19	10
Neurological conditions	46	30	31	16
Heart/circulatory	41	18	41	14
Debility	39	23	46	21
COPD	44	25	45	20
Other	47	23	51	26

Note: COPD (chronic obstructive pulmonary disease). Length-of-stay data reflect the percent of hospice users in 2009 whose hospice length of stay was beyond 180 days.

Source: MedPAC analysis of 100 percent hospice claims Standard Analytic File and denominator file from CMS.

- Above-cap hospices have substantially more patients with very long stays and more live discharges than below-cap hospices for all diagnoses.
- Between 39 percent and 46 percent of above-cap hospices' patients with neurological conditions, heart or circulatory conditions, COPD, or debility had stays exceeding 180 days compared with 18 percent to 30 percent at below-cap hospices.
- For all diagnoses, the live discharge rates at above-cap hospices were at least roughly double, and in some cases almost triple, the rates at below-cap hospices. For example, among patients with heart or circulatory conditions, 41 percent of discharges at above-cap hospices were live discharges compared with 14 percent at below-cap hospices.

Chart 11-19. Margins are higher among hospices with a greater share of their patients in nursing facilities, 2010

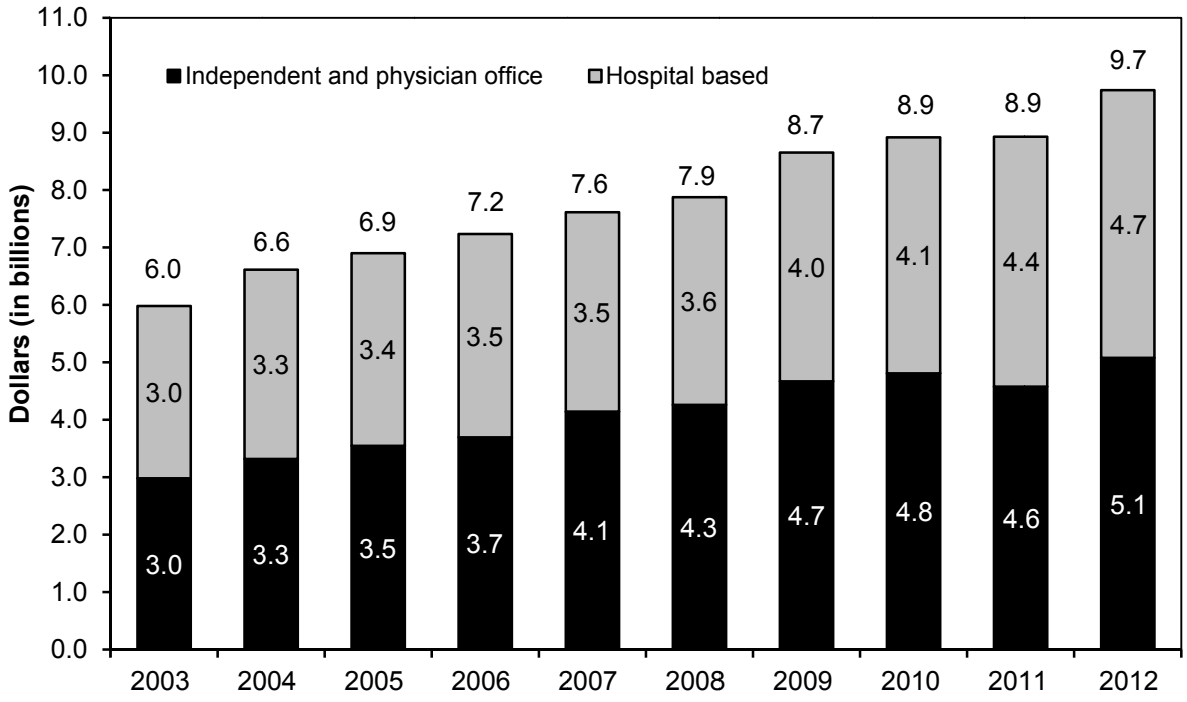


Note: Margins exclude overpayments to hospices that exceed the cap on the average annual Medicare payment per beneficiary. Margins are calculated based on Medicare-allowable, reimbursable costs.

Source: MedPAC analysis of Medicare hospice cost reports and 100 percent hospice claims Standard Analytic File from CMS.

- Hospices with a large share of their patients in nursing facilities have higher margins than other hospices.
- The higher profitability of hospices serving many nursing facility patients may be due to a combination of factors, such as longer lengths of stay, possible efficiencies in treating patients in a centralized location (e.g., less mileage costs and staff time for travel), and overlap in responsibilities between the hospice and the nursing facility.

Chart 11-20. Medicare spending for clinical laboratory services, 2003–2012



Note: Spending is for services paid under the clinical laboratory fee schedule. Hospital-based services are furnished in labs owned or operated by hospitals. Total spending appears on top of each bar. The segments of each bar may not sum to the totals on top of each bar due to rounding. The spending data are calendar year figures from the 2013 annual report of the Medicare Trustees. The spending data include only program payments; there is no beneficiary cost sharing for clinical lab services.

Source: 2013 annual report of the Boards of Trustees of the Medicare Trust Funds.

- Medicare spending for clinical laboratory services grew by an average of 5.6 percent per year between 2003 and 2012. This growth was primarily driven by rising volume, as there were only three increases in lab payment rates during those years (1.1 percent in 2003, 4.5 percent in 2009, and 0.65 percent in 2012).

- Spending for services in all clinical lab settings increased by 9.1 percent in 2012. Spending for services in independent and physician office labs grew by 10.9 percent, compared with 7.1 percent for hospital-based labs.

- Clinical lab services accounted for 1.7 percent of total program spending in 2012.

Web links. Other services

Dialysis

- More information on Medicare's payment system for outpatient dialysis services can be found in MedPAC's Payment Basics series.

  http://www.medpac.gov/documents/MedPAC_Payment_Basics_12_dialysis.pdf

- The United States Renal Data System provides information about the incidence and prevalence of patients with renal disease, their demographic and clinical characteristics, and their spending patterns.

  http://www.usrds.org

- The National Institute of Diabetes and Digestive and Kidney Diseases provides health information about kidney disease for consumers.

  http://www2.niddk.nih.gov/

- CMS provides specific information about each dialysis facility.

  http://www.medicare.gov/dialysisfacilitycompare/

- Chapter 6 of the MedPAC March 2013 Report to the Congress provides information about the financial performance of dialysis facilities.

  http://www.medpac.gov/chapters/Mar13_Ch06.pdf

- MedPAC's June 2005 Report to the Congress recommends changes to how Medicare pays for composite rate services and injectable drugs.

  http://www.medpac.gov/publications%5Ccongressional_reports%5CJune05_ch4.pdf

- MedPAC's October 2003 report describes how Medicare could modernize the outpatient dialysis payment system.

  http://www.medpac.gov/publications/congressional_reports/oct2003_Dialysis.pdf

- MedPAC's comment on revisions to payment policies under the physician fee schedule for calendar year 2004 includes changes in how to pay for services furnished by nephrologists.

  http://www.medpac.gov/documents/100603_RevPhysFeeSched_CB_comment.pdf

- MedPAC commented on CMS's proposed rule to implement provisions of the Medicare Improvements for Patients and Providers Act of 2008 that modernize the outpatient dialysis payment system by broadening the payment bundle in 2011 and implementing a quality incentive program in 2012.

  http://www.medpac.gov/documents/End%20Stage%20Renal%20Disease.pdf

Hospice

- More information on Medicare's payment system for hospice services can be found in MedPAC's Payment Basics series.

  http://www.medpac.gov/documents/MedPAC_Payment_Basics_12_hospice.pdf

- Additional information and analysis related to the Medicare hospice benefit and the financial performance of hospice providers can be found in Chapter 12 of MedPAC's March 2013 Report to the Congress.

  http://www.medpac.gov/chapters/Mar13_Ch12.pdf

- Recommendations for reforms to the hospice payment system and steps to improve accountability and oversight of the benefit can be found in Chapter 6 of MedPAC's June 2009 Report to the Congress.

  http://www.medpac.gov/chapters/Mar09_ch06.pdf

- Additional analyses to support the Commission's recommendations for payment reforms and enhanced accountability, as well as analyses of other issues (i.e., hospice care in nursing facilities and hospice providers with unusually high live discharge rates), can be found in Chapter 5 of MedPAC's June 2013 Report to the Congress.

  http://www.medpac.gov/chapters/Jun13_Ch05.pdf

- CMS maintains a variety of information related to the hospice benefit.

  http://www.cms.gov/Center/Provider-Type/Hospice-Center.html

- CMS also provides information on hospice for its beneficiaries.

  http://www.medicare.gov/Publications/Pubs/pdf/02154.pdf

Clinical laboratory

- More information on Medicare's payment system for clinical lab services can be found in MedPAC's Payment Basics series.

  http://www.medpac.gov/documents/MedPAC_briefs_Payment_Basics_12_clinical_lab.pdf

- Information about CMS's regulation of clinical laboratories, including the number and type of certified labs in the United States, can be found on the CMS website.

  http://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/index.html